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INSURANCE EXCHANGES AND A PUBLIC OPTION

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You requested a history of the public option in the history of the Patient Protection and Affordable Care Act (PPACA) and a discussion of the arguments for and against including a public option as part of the exchanges being established under the act. You also asked whether any states have proposed creating a public option as part of the health care exchanges created pursuant the act and whether federal law permits such an option to be included in an exchange.

The Office of Legislative Research is not authorized to provide legal opinions and this report should not be considered one.

SUMMARY

As used in this report, a public option is a health insurance system administered by a government and offered as an alternative to privately-provided insurance. It thus differs from a single-payer system, where the government is the primary provider of health insurance for all.

A public option was included in the legislation initially passed by the House and Senate, although the Senate bill would have allowed states to exclude a public option from their exchanges.

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After the bills passed, the Democrats lost a seat in the Senate, thereby opening the bill to a filibuster. Senate and House leaders decided to use a mechanism called budget reconciliation, under which a bill cannot be filibustered. The leaders concluded that there was insufficient political support for a public option, particularly in connection with the use of the budget reconciliation mechanism. Thus, they stripped the public option provisions from the bill that eventually passed.

The leading argument for including a public option in a health insurance exchange is that it could reduce the cost of health insurance, primarily by having lower administrative costs than private plans, and thereby make insurance more affordable. Including a public option would also give consumers more choice. On the other hand, including a public option could (1) lead to political pressure to provide taxpayer subsidies for public insurance plans, which could become very expensive and (2) "crowd-out" private insurers, leading to distortions in the health insurance market if the state used its market power to affect payments to providers, among other things.

Much of the discussion of the history of the public option is taken from a Congressional Research Service comparison of the House and Senate bills and a series of articles discussed in *The Atlantic Wire* blog on the elimination of the public option in the final version of the bill. Much of the discussion of the general arguments for and against a public option is taken from a 2009 health policy brief prepared by the Robert Wood Johnson Foundation, available at http://www.rwjf.org/files/research/61809healthaffairs3.pdf.

No state is currently developing a public option for inclusion on its health insurance exchange, according to the National Conference of State Legislatures; although Vermont is considering a single payer system (see OLR Report 2011-R-0288). Moreover, the PPACA, as amended by the Health Care and Education Reconciliation Act, does not appear to permit a public option to be offered on an exchange. The law requires that an exchange make available only qualified health plans (PPACA § 1311). A "qualified health plan" must, among other things, be offered by a health insurance issuer licensed and in good standing to offer health insurance coverage in the state (PPACA § 1301). A "health insurance issuer" is an insurance company, insurance service, or insurance organization (including a health maintenance organization) (1) licensed to engage in the business of insurance in a state and (2) subject to state law regulating insurance (42 USC § 300gg-91(b) (2)). Because the state is not a health insurance issuer, it appears that a public option offered by the state would not be a qualified health plan, and therefore, could not be made available on the state's exchange.

PUBLIC OPTION UNDER THE PPACA

Background

During the 2008 U.S. presidential election, President Barack Obama campaigned for the need to reform the American health care system, stating that health care should be a "right for every American." He advocated the creation of exchanges, where anyone could enroll in a public health insurance plan or an approved private plan. Republican and Democratic legislators introduced 133 health care and related bills in the 2009 Congress. Several of these bills included a public option.

House and Senate Bills

On November 7, 2009, the House voted to approve the Affordable Health Care for America Act (HR 3962) on a 220-215 vote. On December 24, 2009, the Senate approved similar health care reform legislation, the Patient Protection and Affordable Care Act (HR 3590) on a 60-39 vote. Both bills called for the establishment of an exchange in each state, through which individuals not enrolled in (or, primarily in the Senate bill, ineligible for) other coverage, as well as small businesses, could choose from private health insurance plans.

The early drafts of the Senate bill did not include a public option and the Senate Finance Committee voted to reject two amendments that would have created one. In contrast, the House bill would have allowed individuals obtaining coverage through an exchange to choose a public option established by the U.S. Health and Human Services department secretary. An analysis by the Congressional Budget Office (CBO) on HR 3962 (as introduced) estimated that roughly one-fifth of the people purchasing coverage through the exchanges would enroll in the public option, meaning that total enrollment in that plan would be about six million.

On October 26, 2009, Senate majority leader Harry Reid announced that a new Senate bill would include provisions from the earlier Senate bills and would include a public option from which states could opt out. The Senate subsequently adopted this bill. Unlike the House bill, the Senate bill would have allowed states to prohibit a public option in their exchange. The Senate bill would also have allowed states to require the public option to include additional benefits, a provision not included in HR 3962. Thus, under the Senate bill, individuals purchasing insurance in an exchange might not have access to a public option, and if they had access to a public option, the benefits might differ from state to state; under the House bill, the exchange would always include a public option with standardized benefit levels.

Another difference between the House and Senate bills pertains to the establishment of provider networks. Under H.R. 3962, the provider network for the public option would be established by deeming Medicare-participating providers to also be providers under the public option, unless they opted out in a process established by the secretary. In contrast, the Senate bill specified that provider participation would be voluntary, leaving open the question of whether a provider network would be established through an opt-in process. HR 3962 further allowed providers to participate in the public option either as preferred or non-preferred providers, which would allow non-preferred providers to bill for amounts above the established payment rates in a manner similar to physician participation rules under Medicare; the Senate bill did not include a comparable provision.

Under both bills, the public option would be appropriated start-up funding, but would ultimately have to be self-sustaining through the premiums charged. Premiums for the public option would be set according to new market reform rules at a level sufficient to cover the cost of medical claims, administration, a contingency margin, and repayment of the start-up funding.

Final Bill

After the Senate passed its version of the bill, Senator Ted Kennedy died and in January 2010 was replaced by Scott Brown, a Republican, in a special election. As a result, the Democrats had only 59 votes in the Senate, insufficient to block a filibuster without Republican support.

Since more than 40 senators had opposed all or part of the Senate version of the bill, House and Senate leaders decided to proceed with the bill using a mechanism called budget reconciliation to avoid the possibility of a filibuster. Under the normal rules of the Senate, debate on bills has no time limit and 60 votes are required to end debate and bring a bill to a final vote. When a bill is considered under the rules of budget reconciliation, debate is limited to 20 hours and ending debate requires only a simple 51-vote majority. The mechanism was used to pass major deficit reduction and tax-cutting legislation under presidents Bill Clinton and George W. Bush.

On February 22, 2010, President Obama unveiled his own healthcare proposal, which drew heavily from the Senate bill. The final bill, passed by the House and Senate and signed by the president, includes exchanges but not a public option. A table prepared by the Kaiser Family Foundation compares the major provisions of the final bill to the previous versions adopted by the House and Senate.

Commentators have advanced a variety of theories as to why the administration agreed to drop the public option in the final version of the bill. Perhaps the most commonly cited reason was that there was an insufficient number of votes for a public option to be adopted. For example, Obama spokesman Robert Gibbs stated at a press conference on February 23, 2010 that there was not enough political support among Democratic legislators to get a public option through Congress. Similarly, when asked at a March 25, 2010 speech in Iowa City, Iowa, why the public option was not included, Obama responded, "Because we couldn't get it through Congress, that's why."

In his website fivethirtyeight.com, analyst Nate Silver argued that it was unclear how much support a public option had among Senate Democrats. In committee, three Democratic senators had voted against a public option proposal introduced by Senator Schumer, and five had voted against a proposal introduced by Senator Rockefeller. According to Silver, in August 2009, a whip count on the public option showed only 43 firm yes votes in the Senate, one of whom was Senator Kennedy. Stephen Benen, writing in the February 23, 2010 edition of the *Washington Monthly*, suggested that dropping the public option was needed to get the support of so-called blue dog (conservative) Democrats in the House. A number of Democratic legislators were specifically unwilling to support a public option when using the reconciliation mechanism

Several commentators argued that Obama was only lukewarm in his support of a public option. For example, the columnist Ezra Klein argued in the February 23, 2010 edition of the *Washington Post* that Obama failed to provide leadership to defend the public option in the face of opposition from the health insurance industry. Marc Ambinder, writing in the February 23, 2010 edition of *The Atlantic*, claimed that the administration had "expended no time or energy building support in the Senate for a public option."

PROS AND CONS OF INCLUDING A PUBLIC OPTION IN AN EXCHANGE

Pros

Supporters of a public option within an exchange believe it would make coverage more affordable and buy the most health care for the dollar. They believe that administrative expenses for things such as marketing, advertising, and personnel would be lower in a public plan than for private insurers. Proponents of a public option note that the administrative costs of the public Medicare program are substantially less than those for the Medicare Advantage plans administered by private insurers. In part this difference is due to the fact that a public plan would not need to generate returns for investors, as is the case for private insurers.

Similarly, cost comparisons between Medicaid and private coverage indicate that a public option could save money. A 2008 study published in the journal *Health Affairs* compared the cost of Medicaid coverage to that of private insurance for adults, after accounting for health condition, age, sex, race, education, and other factors. It found that if an average low-income adult with Medicaid switched to private health insurance for one year, coverage would cost 26%, or $1,455, more per person, and out-of-pocket expenses would be roughly 6.5 times, or $1,096, more (including deductibles, copayments, and medical services not covered by private insurance). The difference is due to several factors, including higher out-of-pocket expenses in private plans and lower payment rates to providers in Medicaid.

Advocates believe that a public option could generate savings in other ways. A large public plan could have greater bargaining power with doctors and hospitals. A public option could also demonstrate to commercial insurers "how to provide good coverage at a reasonable cost with transparency and stability."

Finally, a public option would provide an additional choice for consumers, some of whom might prefer public over private coverage. A 2012 consumer survey conducted by the Commonwealth Fund found that Medicare beneficiaries are more satisfied with their coverage than comparable individuals with private coverage. After adjusting for income, health status, and the presence of chronic conditions, the study found that only 8% of Medicare beneficiaries ages 65 and older rated their insurance as fair or poor, compared with 20% of adults with employer insurance and 33% of those who purchased insurance on their own. Adults with employer-based insurance or individual insurance reported

medical bill problems at almost double the rate of Medicare beneficiaries. And about one-fourth of Medicare beneficiaries went without needed care because of costs, compared with 37% of adults with employer coverage and 39% of those with individual coverage.

Cons

One argument against including a public option in an exchange is that it could open the state to political pressure to provide subsidies to reduce or stabilize the costs of health insurance. As noted above, the House and Senate bills required the public option to be self-sufficient, but critics argued that it would end up being like Medicare or Medicaid, which rely heavily on taxpayer funding. If health care costs continue to rise, due to an aging population and technological developments that provide treatments for disease that are currently untreatable, participants and providers could argue for taxpayer funding and this pressure could be difficult to resist, potentially opening the state to severe fiscal pressures.

Also, if the public option were successful in offering coverage at lower costs than private plans, this could "crowd out" the private plans, potentially leading to consumers choosing the public option instead of private insurance, thus leading private insurers to leave the market and giving consumers fewer choices. According to a CBO study, after Congress created the Children's Health Insurance Program (CHIP) in 1997, enrollment of children in private health insurance plans declined, as parents chose instead to enroll their children in CHIP. The CBO concluded that for every 100 children who joined the public insurance program, 25–50 children disenrolled from a private plan.

If the public option became a dominant participant in the insurance market, this could destabilize the health insurance marketplace. If the state became a major buyer of health insurance it could in effect control prices charged by health care providers and choke competition.

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